



Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address:

Diagnostic Imaging Institute, Inc.
P.O. Box 743125
Dallas, TX 75374

MFDR Tracking #: M4-08-0155-01

Respondent Name and Box #:

Ace American Insurance Co
Rep. Box#: 15

In

Ins

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Requestor's Position Summary: "Required testing by designated doctor exam."

Principal Documentation:

1. DWC 60 package
2. Total Amount Sought - \$306.08
3. CMS 1500s
4. Proof of Request for Reconsideration

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Respondent's Position Summary: None Provided

PART IV: SUMMARY OF FINDINGS

Eligible Dates of Service (DOS)	CPT Codes	Denial Codes	Part V Reference	Amount Ordered
09/05/06	97750-FC	NO EOB	1 - 3	\$306.08
Total Due:				\$306.08

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule 134.202, titled *Medical Fee Guideline* effective August 1, 2003, set out the reimbursement guidelines.

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

1. The Requestor has submitted convincing evidence of carrier receipt for "Request for EOB(s)" in accordance with 133.307 (e)(2)(B). Neither the Respondent nor the Requestor provided EOB(s) for these services. The billings will be audited accordingly per Rule 134.202.
2. This FCE was performed per §134.202(e)(4) as required testing to support a Designated Doctor exam and is not part of the three (3) FCE limitations for FCE(s). Per §134.202(c)(1), the MAR is \$30.61 x 125% x 8 units (2 hrs), therefore, Requestor is entitled to reimbursement totaling \$306.08.
3. Per review of Box 32 on CMS-1500, zip code 77401 is located in Harris County. The maximum reimbursement amount, under Rule 134.202(b), is determined by locality.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Section 413.011(a-d), Section 413.031 and Section 413.0311
28 Texas Administrative Code Section 134.1, Section 134.202
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Requestor is entitled to reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of \$306.08 plus applicable accrued interest per Division Rule 134.130, due within 30 days of receipt of this Order.

ORDER:


Authorized Signature


Medical Fee Dispute Resolution Officer

11/06/07
Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within 20 (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed \$2,000. If the total amount sought exceeds \$2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

Eric C. Foigt
- 347-7870 -

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